

STAFF IMMUNIZATION HISTORY FORM

NAME _____

BIRTHDATE ____/____/____

Teachers of young children, day care employees, and residents and staff in institutional settings should be vaccinated. Non-pregnant women of childbearing age and international travelers who do not have evidence of immunity should be vaccinated as well.

MEASLES*

One dose of live measles vaccine administered on or after one year of age; or laboratory evidence of measles immunity. (Not required of those born before January 1, 1957)

Date of Vaccine: ____/____/____
Month/Day/Year

Documentation of Measles Immunity

I certify that the person named above has laboratory evidence of immunity to measles virus and does not need measles vaccine.

Titer Result

Physician's Signature or Stamp

____/____/____
Date

RUBELLA*

One dose of rubella vaccine administered on or after one year of age; or laboratory evidence of rubella immunity. (Not required of those born before January 1, 1957)

Date of Vaccine: ____/____/____
Month/Day/Year

Documentation of Rubella Immunity

I certify that the person named above has laboratory evidence of immunity to rubella virus and does not need rubella vaccine.

Titer Result

Physician's Signature or Stamp

____/____/____
Date

MUMPS*

One dose of vaccine administered on or after one year of age. (Not required of those born before January 1, 1957 or those who had mumps disease.)

Date of Vaccine: ____/____/____
Month/Day/Year

*Measles, Mumps, and Rubella are commonly administered together in the MMR vaccine.

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)**/ TETANUS-DIPHTHERIA (Td)

One dose of Tdap should replace a single Td booster. After one dose of Tdap, adults should continue getting Td boosters every 10 years.

Date of Tdap Vaccine: ____/____/____
Month/Day/Year

Date of Td Vaccine: ____/____/____
Month/Day/Year

**Adult Tdap immunization recommendations are provisional. Recommendations will become final when they are published in the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report.

I certify that the information provided above is correct.

Signature

____/____/_____
Date

Exemption

In the event of an outbreak of vaccine preventable disease from which you are exempt, you may be excluded from work for the duration of the outbreak. I am opposed to immunizations and do not want to have any vaccines; or I do not want to receive the following vaccines:

☐ Religious ☐ Personal

Vaccine

Signature

____/____/_____
Date

Hepatitis B Immunization Consent/Waiver Form

Please print

Employee's Name

Employer's Name

Employer's Address

Position

I attended the hepatitis B education and training class on ____ / ____ / ____ and:
Date

1. I understand a series of three injections of hepatitis B vaccine is needed to be completely protected.*
*Occasionally, more vaccine is needed if the first series does not result in immunity.
2. If I do not become protected from receiving the vaccine, or if I choose not to receive the vaccine at this time, I understand I will need post-exposure treatment if I have direct contact with blood or other body fluids at work.

I have read and I understand the above information and wish to receive the hepatitis B vaccine series (three doses). Also, I have *no known* sensitivity to *yeast*.

Signature Date ____ / ____ / ____

3. I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I have read and I understand the above information and *do not* wish to receive the hepatitis B vaccine series (three doses) at this time.

Signature Date ____ / ____ / ____

A. Medical Reason for Employee Not Receiving Vaccine

☐ Yes ☐ No

Explanation if Yes _____

B. Hepatitis B vaccination record

Dose #1 ____ / ____ / _____

Dose #2 ____ / ____ / _____

Dose #3 ____ / ____ / _____

Dose #4 ____ / ____ / _____

Dose #5 ____ / ____ / _____

Dose #6 ____ / ____ / _____

C. Hepatitis B serological Tests

HBsAg _____ ____ / ____ / ____

Anti-HBsA ____ / ____ / ____